MEASURING PROGRESS TOWARD UHC IN GHANA: REPORT ON TECHNICAL ASSISTANCE TO THE MINISTRY OF HEALTH

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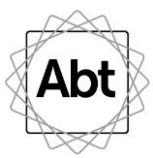

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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ACRONYMS

CHIM	Centre for Health Information Management
CHPS	Community Health Planning and Service
DHIMS2	District Health Information Management System
DOH	Department of Health
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GOG	Government of Ghana
HAT	Holistic Assessment Tool
HFG	Health Finance and Governance
HIV	Human Immunodeficiency Virus
HSMTDP	Health Sector Medium-term Development Plan
HT	Hypertension
IME	Information Monitoring and Evaluation
IMR	Infant Mortality Rate
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOLG	Ministry of Local Government
NCD	Non-Communicable Disease
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
PMTCT	Prevention of Mother-to-Child Transmission
PPME	Policy, Planning, Monitoring and Evaluation
SWI	Sector-wide Indicator
TBA	Traditional Birth Attendant
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Ghana has made steady, albeit slow progress toward its goal of health for all Ghanaians since it formulated its primary health care strategy in the late 1970s. The strategy has evolved over time to focus on access to quality health services for all and on financial risk protection. The Ministry of Health (MOH) and its agencies have developed an elaborate monitoring and evaluation (M&E) system to measure progress toward the stated goals. However, gaps remain in defining appropriate core indicators for equity and financial risk protection that can also be compared internationally.

The Health Finance and Governance (HFG) project, funded by the United States Agency for International Development, provided technical assistance to the MOH to promote and enhance ongoing routine measurement of progress toward universal health coverage (UHC).

Following are the key findings and recommendations that emerged from the activity:

1. Ghana has laid a good foundation for achieving UHC. It has provided policy and legal frameworks to achieve UHC, including implementing the Community Health and Planning Service program and the National Health Insurance Scheme. The MOH has developed a practical Monitoring and Evaluation (M&E) Framework to monitor such progress and it implements a robust annual review process that involves all key stakeholders in the health sector. The MOH is working with its agencies to develop a functional definition of UHC that is expected to build on a strategic framework outlined by an informal think tank of experts. The MOH through its Directorate of Policy, Planning, Monitoring and Evaluation (PPME) should draw on the work of the think tank for its country-specific definition.
2. Currently available data sources and monitoring processes can provide essential indicators for measuring progress toward achieving UHC. Few if any new ones need to be introduced.
3. There are overlaps, duplications, and misalignments within and between major indicator sets. For example, sector-wide indicators in the M&E Framework 2014, the Health Sector Medium-term Development Plan (HSMTDP) 2014–2017, the Holistic Assessment Tool Report 2015, and the Medium-term National Development Policy Framework differed in structure and content even where they were expected to be similar.

   To harmonize the major indicator sets, PPME directors and the Ghana Health Service (GHS) must provide stronger leadership and guidance to the Information Management and Evaluation (IME) health sector working group, which is mandated to review sector-wide indicators and recommend changes to the indicator sets. The process will require enhanced coordination and effective communication among all health service actors.
4. Most of the tracer indicators recommended or under consideration by the international community are routinely available in Ghana.

   The Chief Director of the MOH must assign to the IME working group the specific task of finalizing and obtaining approval for a set of tracer indicators based on the results of this technical assistance. It should be completed in time for use in the next HSMTDP, 2018–2021.

   To minimize the tendency to continually expand the range of indicators, a cap should be placed on the number of tracer indicators for a defined period of time. The author recommends a maximum of 20 for a two-year period.
5. The existing health sector M&E framework and procedures are elaborate and have in-built mechanisms for revising indicators and tools for data collection.

The MOH and GHS should add value to the M&E Framework and procedures by insisting on their use by all agencies. This requires accurate and timely communication on data needs and encouraging (through rewards and disincentives) a habit of using data for decision-making at the points of collection as well as at managerial and policy levels.

6. There are important gaps between the desired UHC measurements and the current situation. These include:

   - Input gaps, for example, inadequate knowledge and competences to conduct M&E activities;
   - Output gaps, for example, failure to update data collection tools in line with changing priorities and emerging programs, and persistent failure of health workers and managers to use existing data to for evidence-based decision-making;
   - Output/Outcome gaps, for example, poor data quality.

   To address these persistent gaps that retard progress in monitoring requires firm leadership of health sector stakeholders by key managers of the health sector (Chief Director of the MOH, assisted by the directors of the MOH PPME Directorate and the GHS).

1. INTRODUCTION

Since Ghana's independence in 1956, each ruling government has aimed to provide good-quality health services to the entire population of Ghana. In the late 1970s, the Ministry of Health (MOH) formulated a primary health care strategy based on the core goal of Health for All by the Year 2000 strategy, and overall there has been consistent, albeit slow progress toward this goal. Implementation of the strategy has evolved in tandem with global trends. The adoption in September 2015 of 17 Sustainable Development Goals – including Goal 3, to "ensure healthy lives and promote well-being for all at all ages" – has re-focused attention on progress toward Health for All.

Over the past decades, the MOH and its agencies have developed an elaborate monitoring and evaluation (M&E) system to measure progress toward health sector goals. However, challenges remain in defining appropriate and internationally comparable indicators for tracking progress toward achieving the universal health coverage (UHC) core aspects of equity, quality, and financial risk protection.

The United States Agency for International Development (USAID)-funded Health Finance and Governance (HFG) project collaborated with the MOH to enhance the ongoing process of defining essential indicators for measuring progress toward UHC. HFG conducted a comprehensive review of sector-wide indicators (SWIs) used by the MOH. This complemented work underway by the MOH to review its M&E Framework 2014 (MOH 2014a) and to develop a new Health Sector Medium-term Development Plan (HSMTDP), for 2018–2021.

1.1. Process and Methodology

The HFG consultant's focal point for this study was the director of the MOH Directorate of Policy, Planning, Monitoring and Evaluation (PPME). The MOH established an ad hoc technical working group (TWG) on UHC (see Annex A for a list of TWG members) to provide overall guidance for the technical assistance. Specifically, the TWG discussed and endorsed the work plan, provided expert opinion on how key tasks should be conducted, and reviewed findings and progress reports. The consultant contributed technical assistance via regular and ad hoc meetings in person and by telephone and email. Planning staff of the PPME Directorate served as the secretariat for the technical assistance.

1.2. Literature Review

The study began with an extensive literature review of publications on UHC and health systems. Several publications were sourced from the Internet, the HFG team, and the director of the PPME directorate and his team.

Three publications in particular provided context and content for this report: *Tracking Universal Health Coverage: First Global Monitoring Report* (WHO and World Bank 2015), *Monitoring and Evaluation Framework* (MOH 2014a), and *Monitoring and Evaluating Progress toward Universal Health Coverage in Ghana* (Nyonator et al. 2014). These were supplemented with other literature including the report *Monitoring Progress toward Universal Health Coverage at Country and Global Levels* (Boerma et al. 2014).

The World Health Organization (WHO) and World Bank report (2015) provided a "best practice" set of standard indicators to measure UHC progress while the study by Nyonator et al. (2014) and interviews with key informants provided background on the status of UHC monitoring in Ghana.

The provisional findings of the technical assistance were discussed with the TWG in November and subsequently revised.

1.3. Consultation, Interviews, and Meetings

The consultant interviewed MOH officials and representatives of regulatory agencies and development partners in health (see Annex B for a list of agencies interviewed). The objective of these interviews was to learn if these key players in the health sector have a corporate view on measuring progress toward UHC and to gain some insight into how they intend to engage with the MOH in achieving UHC. The discussion topics are presented in Annex C.

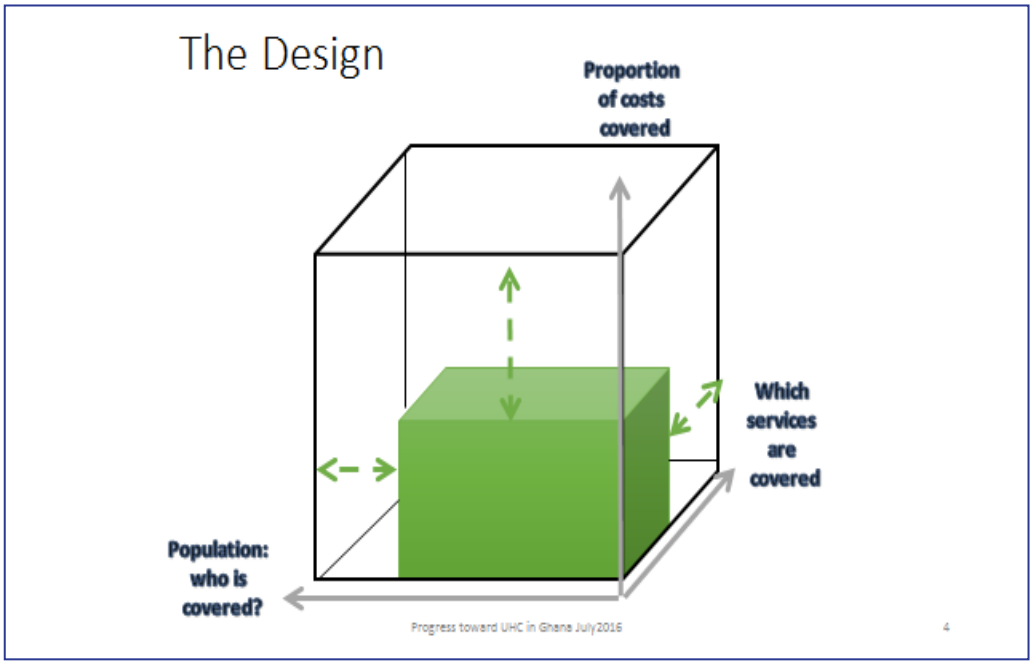
2. RESULTS

2.1. The Global View on UHC and Its Monitoring

The WHO defines UHC as ensuring that all people receive the quality health services they need without incurring financial hardship (WHO and World Bank, 2015). This definition is depicted as a three-dimensional space with axes representing population, health service and costs covered (see Figure 1). A smaller solid box (in green) represents the current status of each of these dimensions in a particular country. The goal should be to reduce the gap between the actual and the desirable.

Boerma et al. (2014) emphasized that the components of a package of needed good quality health services and protection from financial hardship are closely interrelated. Progress on delivering both components should be measured simultaneously and must capture all levels of the health system. All measures should be disaggregated by socioeconomic and demographic characteristics where relevant in order to allow assessment of equitable distribution and use of services and financial risk protection.

Figure 1: A Model of UHC



2.2. Indicators for Tracking Coverage

A WHO and World Bank task force has identified eight tracer indicators, two candidate tracer indicators, and five promising health service indicators for tracking progress toward UHC (WHO and World Bank 2015). These are discussed later in this report.

Evidence from a summary of 18 country case studies suggests that tracking of effective coverage is mostly dependent on a well-developed surveillance system that enables comparison of different sets and sources of data (Boerma et al. 2014). The publication recommended that countries focus on regular monitoring of progress toward set targets for priority health services and for the occurrence of financial hardship through the use of tracer indicators.

2.3. Context for UHC in Ghana

Key finding 1: Ghana has laid a good foundation for achieving UHC.

Ghana has legal provisions and policies for access to health for all Ghanaians. These are in the Constitution of 1992, the Government's Developmental Agenda "Toward Vision 2020," and the Health Sector Medium-term Development Strategy 1997–2001. The strategy emphasizes that the purpose of health sector reforms in Ghana was to "Provide universal access to basic health services and improve the quality and efficiency of health services, as well as foster linkages with other sectors." The law establishing Ghana's National Health Insurance Scheme (NHIS) provides financial risk protection from the cost of basic health care for all residents in Ghana; all Ghanaians are required to join the NHIS. The NHIS benefit package covers about 95 percent of the diseases affecting Ghanaians. Several categories of Ghanaians who cannot pay the premium or represent special groups are exempted from paying. These include the indigent, children, pregnant women, those above 70 years of age, and persons with mental disorders.

An informal think tank on UHC[1] was set up in September 2016 to facilitate the recommendation of the PPME Directorate's UHC TWG to articulate a UHC strategy for Ghana. The group regards the existing policy and strategy on primary care as sufficient to guide the country toward its goal of UHC. It recommends that Ghana should place equal emphasis on access to an essential health package and on financial risk protection, and not mainly on the latter as key national discussions tend to do. The challenge is for the health sector to design strategies that will accelerate progress toward full coverage of both dimensions. The MOH has also initiated discussions aimed at mobilizing support for the review and update of Ghana's primary health care strategy to be aligned with UHC.

A large percentage of the population has traditional cultural beliefs and practices on illness, and seeks health care outside Ghana's formal health services. These activities are not captured in the M&E framework. Current monitoring of UHC can, at best, only present the picture for that part of the population using the formal health sector.

[1] Members of the think tank are Mr. Kwamina Ahwoi, Governance and Decentralization expert; Dr. Koku Awoonor Health Systems/CHPS expert; Dr. Nana Enyimayew, Health Systems expert (Convener); Dr. Frank Nyonator (Facilitator); Dr. E. Odame, Health Policy expert; Dr. Anthony Ofosu, M&E expert; Mr. Nathaniel Otoo, NHIS Executive; and Dr. Andrew Ayim, Public Health practitioner (Secretary).

2.4. A Review of UHC Measurement in Ghana

This section discusses indicators and tools used for monitoring progress toward UHC with a focus on availability and suitability.

2.4.1. Indicators used to measure health service and financial risk protection

Key finding 2: Currently available data sources and monitoring processes can provide essential indicators for measuring progress toward achieving UHC. Few if any new ones need to be introduced in the short term.

The health sector routinely collects 287 indicators for nine groups of health conditions, programs, and services. The full set is published in the MOH's M&E Framework 2014 as the comprehensive set of indicators in the health sector. A summary of them is presented in Annex E.1. A shorter list of 40–54 SWIs that serve as proxy measures for overall health sector performance has been drawn from this longer list and grouped under six health sector objectives[2] (see Box 1 below and Annex E.2).

Box 1: Ghana's Health Sector Objectives Provide a Framework for Monitoring UHC Progress

1. Bridge equity gaps in geographical coverage
2. Ensure sustainable financing and financial protection for the poor
3. Improve efficiency in governance and management of the health system
4. Improve quality of health services delivery including mental health
5. Enhance national capacity to attain the health-related Millennium Development Goals and sustain the gains
6. Intensify prevention and control of non-communicable diseases (NCDs) and other communicable diseases

Though the SWI list was originally intended as a short list to provide a "snapshot" of overall health sector performance, it has increased over the years to the current list of 53 indicators published in the MOH's M&E Framework 2014 as sector-wide indicators for HSMTDP 2014-2017.[3] Key informants interviewed consider the list to be too long and unwieldy to provide the required "snapshot" of health sector performance.

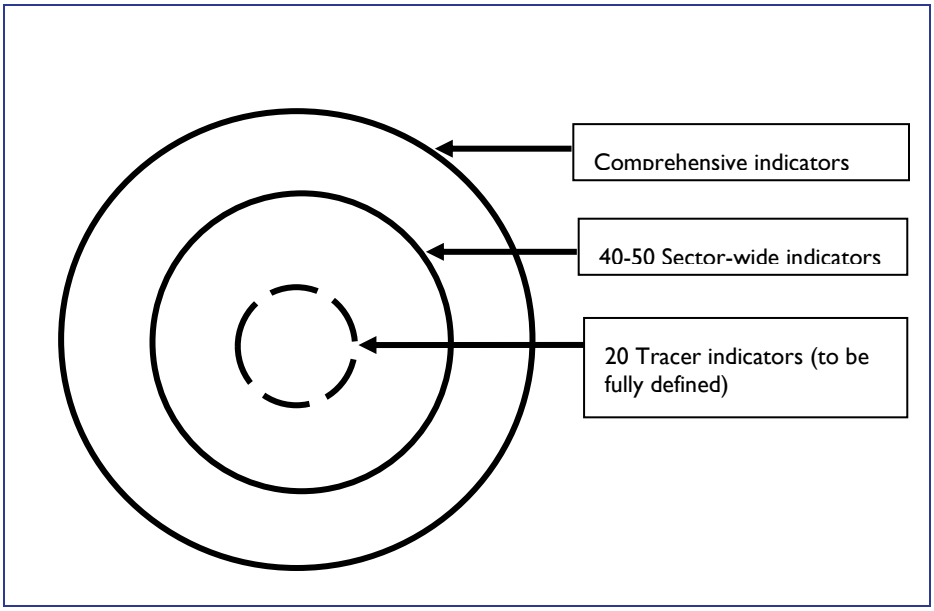
Key finding 3: There are overlaps, duplications, and misalignments within and between major indicator sets.

Compounding the problem of this unwieldy "short" list of SWIs is the fact that multiple versions are currently in use by the MOH. The indicator lists in the MOH M&E Framework 2014, the HSMTDP 2014-2017 and the Holistic Assessment Tool (HAT) 2015 are all currently in use but differ in some ways in content and phrasing. (Annex E.2 points out some of these differences.) The National Development Planning Commission, which coordinates sector plans for national development, also quotes health sector indicators that differ in some respects from the three sets mentioned. (Commission indicators are in Annex E.3.)

[2] Prior to 2014, health sector programs were guided by five strategic objectives. These were expanded to six in the current HSMTDP (2014–2017).
[3] HSMTDP 2014-2017 refers to the Health Sector Medium-term Development Plan for the period 2014 to 2017.

A consistent and harmonized set of indicators would give managers and planners a common reference point for comparison and for planning. Creating such a list will require better coordination of review activities with timely and effective communication of proposed changes. Figure 2 depicts the proposed harmonization among indicator sets. It has a comprehensive set of all indicators generated by the health sector and subsets generated for specific purposes. The inner core represents the proposed set of tracer indicators for monitoring UHC.

Figure 2: Harmonized Indicator Sets for M&E



2.4.2. Data sources and types

Health sector data come from two main sources. The first source is health facilities and other service delivery points; their data are collected on a routine basis. The second source is population-based surveys; the most commonly known of these is the Ghana Demographic and Health Survey (GDHS), conducted every five years by a team of national and international institutions. The most recent GDHS, for 2014, reported 139 indicators on Ghanaians' health and population characteristics. These indicators were organized under 15 headings (see Annex E.4).

Other data sources that are relevant for monitoring progress toward UHC are the National Population Census, HIV/AIDS Sentinel Survey, published annually, the Multiple Indicator Cluster Survey (MICS) reports, Ghana Living Standards Survey, National Health Accounts, and the Demographic Surveillance Systems of GHS's Kintampo and Navrongo Research Centers. These are listed and briefly described in Annex E.5.

Key finding 4: Most of the tracer indicators recommended or under consideration by the international community are routinely available in Ghana.

The WHO and World Bank-proposed set of tracer indicators (see Annex F) offers a starting point for defining a set of indicators. Criteria for selecting such indicators are listed in Box 2.

Box 2: Criteria for Selecting Tracer Indicators

Criteria are taken from Boerma et al. (2014) and Nyonator et al. (2014).

1. Epidemiological relevance (i.e., should measure an intervention associated with a significant proportion of the burden of disease)
2. Data availability (from health facility and from population-based surveys)
3. Few in number
4. Cost-effective intervention (i.e., known to be effective and feasible to deliver)
5. Measurable numerator and denominator
6. Target (i.e., should capture 100% of target population)
7. Equity (i.e., indicator can be disaggregated by sex, age, household wealth/income, rural/urban residence, as a minimum)
8. Quality (i.e., intervention must be delivered with quality necessary to achieve the desired outcome)
9. Comparable over time and across countries
10. Easy to communicate

Twelve of 16 WHO/World Bank tracer indicators are currently reported either through health facility data collection (via the District Health Information Management System, (DHIMS2)) or by the GDHS.

Monitoring access: Most of the tracer indicators are suitable for monitoring quality of care and coverage.

Monitoring equity: Though the list of tracer indicators in Annex F do not specifically include equity measures, Nyonator et al. (2014) demonstrated that disaggregating them by sex, age, place of residence, and income levels will provide useful equity measures. Table 1provides an example that compares selected indicators by wealth quintile or place of residence and provides a measure of inequity. Most of the data generated for Ghana's SWIs are already disaggregated by age, sex, and district/region and can provide useful equity measures.

Table 1: Health Sector Performance on Equity, Ghana 2012

Indicator	Target	Performance	Source
Equity: Under-five mortality ratio: Comparing the fifth wealth quintile to the first wealth quintile	1:1.5	1:2.04	MICS
Equity: Geography – Services: Supervised deliveries comparing the best performing region to the worst performing region	1:1.70	1:1.53	GHS
Equity: Geography – Nurse: population ratio comparing the best performing region to the worst performing region	1:1.95	1:1.75	MOH

Monitoring financial risk protection: At the end of 2016, the Inter-Agency and Expert Group on Sustainable Development Goals proposed a revision of Goal 3, Target 3.8, "Number of people covered by health insurance or a public health system per 1000 population" to one that is judged to be more valid, namely "Proportion of population with large household expenditures or income as a share of total household expenditure or income." The GDHS in 2014 provided data on the former indicator plus one on "Percentage of population covered by National/District Health Insurance Scheme who made out-of-pocket payments for medicines and services," which could serve as a proxy measure of financial burden until a more valid indicator is assessed either by the next GDHS or other household expenditure survey. According to key

informants, the possibility of more frequent population-based surveys to measure financial risk protection has been discussed among health sector stakeholders but the high cost of such surveys prevents such action being taken. Discussion on the use of estimates from rigorous transparent modelling techniques that make use of health facility data and most recent survey estimates are ongoing. These estimates will be of great relevance to UHC monitoring when available. An example of such modelling is the HIV estimates that are generated annually using the SPECTRUM software.

2.4.3. Monitoring framework

Key finding 5: The existing health sector M&E Framework and procedures are elaborate and have in-built mechanisms for revising indicators and tools for data collection.

The MOH's M&E Framework 2014 is based on the premise that MOH agencies have M&E systems in place and that all agencies and relevant stakeholders report periodically on the services provided within the framework of agreed indicators and formats (MOH 2014b). The framework's goal and objectives are presented in Box 3.

Box 3: Goal and Objectives of M&E Framework 2014

Goal: To have a coordinated and effective M&E mechanism that will support evidence-based decision-making and accountability in the health sector.

Objectives:

1. Provide a comprehensive and objective basis for measuring health sector performance
2. Define roles and responsibilities of stakeholders

The framework also prescribes frequency and timing of reports and spells out reporting channels. Data collection, collation, and analysis can take place at all levels of service delivery through the DHIMS2 platform. The system uses one standardized data entry form, offering one entry point for coordinating all M&E activities of the health sector. There is regular, periodic publication of collated data. Overall, this has resulted in a reduction of vertical data reporting and multiple databases and should facilitate future performance reviews of the health sector.

2.4.4. Monitoring and review processes

Health facilities collect and report on most of the 287 indicators in the comprehensive set provided in the M&E Framework. These are submitted monthly or quarterly up the hierarchy of service management. The district health management team and district hospital record the data in the DHIMS2 for submission to regional/national levels. The DHIMS2 has been recognized internationally as a best practice tool in M&E.

Joint supervision and monitoring visits from a management level to the next lower levels are conducted quarterly. Supervision is more frequent between the district management and the subdistrict structures than between higher levels and the districts. In addition, the MOH carries out an annual health sector review consisting of meetings at facility and district levels that are built up through the regional level to a national performance review meeting of all health sector stakeholders. Performance is evaluated against targets set in the HSMTDP 2014–2017. In-depth review by an independent team of national and international experts complements the annual review process by evaluating performance of specific issues or programs of priority concern to the sector. The full cycle ensures that all stakeholders at all levels of the health services have an opportunity to participate in reviewing the performance of the health sector.

2.5. Gap Analysis of Existing Measurement

Key finding 6: There are important gaps between the desired UHC measurement and the current situation.

To effectively monitor progress toward UHC, Ghana needs:

- **A definition of UHC for the Ghanaian context**: A country-specific definition for UHC is in progress but the MOH and GHS need technical assistance to accelerate its completion in time to shape the next HSMTDP (2018–2021).
- **A sector plan** to guide implementation of programs that will accelerate progress toward UHC: The first steps toward the next HSMTDP have been taken. The Director-General of the National Development Planning Commission requested at the beginning of 2017 that all sectors review their performance on the current medium-term plan in preparation for the next plan, which should be ready by the end of 2017. A calendar of planning workshops will be announced in the first quarter of 2017. The MOH and its agencies and partners will work together to prepare the plan, which will be expected to state clear commitments to UHC.
- **A set of tracer indicators** to provide a good picture of the progress toward core objectives and targets, meeting the criteria listed in Box 2: There is no officially approved set of tracer indicators. The provisional list proposed in this report can serve as the starting point for defining a final set of tracer indicators.
- **An M&E framework and process** that provide complete, accurate, and timely data and are sufficiently robust to accommodate the present and future needs of stakeholders in the health sector: A number of shortcomings must be addressed to ensure more reliable data for monitoring UHC progress. These include:
  - Input gaps
    - Inadequate knowledge and competences to conduct M&E activities
    - Occasional stock-outs of data collection tools
  - Process gaps
    - Failure to update data collection tools in line with changing priorities and emerging programs
    - Absence of reliable indicators to monitor cancers, mental illness, injuries, and other NCDs that make a significant contribution to the burden of disease
    - Failure to enforce reporting obligations of the private for-profit sector
    - Exclusion of activities of the non-formal, traditional, and faith-healing subsectors in the M&E Framework
    - Persistent failure of health workers and managers to use existing data for evidence-based decision-making
  - Output/Outcome gaps
    - Poor data quality; incomplete, inaccurate, and late reporting

2.6. Stakeholders' Perspectives on UHC

All stakeholders interviewed regarded UHC as a desirable goal to pursue even though most development partner organizations did not, as yet, have explicit policies or statements on it. They regarded UHC as a continuation of the primary health care strategy that had shaped Ghana's health service development over the past years and noted that their own programs and assistance were aligned to the HSMTDP.

When asked to discuss indicators that were most relevant for their own goals and objectives (especially in the context of the HSMTDP), it became evident that all respondents wanted health institutions to collect indicators that were very specific to their needs, some of which they expressed as gaps in measurement of progress toward UHC. Examples included data on functionality of Community Health Planning and Service compounds, data on availability and use of drugs and pharmaceuticals, data on financial flows and expenditure, and reliable population data for estimating rates. Gaps were also identified in the gender distribution of reported conditions, especially for children and adolescents. Others expressed concern about the quality of data, the use of nonstandardized definitions of some indicators, and the inability to obtain timely and accurate information.

Several development partners have developed parallel reporting systems even while acknowledging the strengths of the DHMS2, the HAT, and the other official sources. This could undermine the official M&E system.

3. ACTION PLAN TO ADVANCE UHC MEASUREMENT

3.1. Short-term Action Plan

Table 2 outlines an action plan of recommended actions and persons responsible to advance UHC measurement efforts over the next 12 months.[4]

Table 2. Broad Tasks and Timeline

Task	Responsible Party	Timeline
A. Formulate a definitive UHC strategy for Ghana through consultation and consensus with health sector and related agencies (ongoing)	MOH Chief Director	2016-Mar 2017
B. Build consensus on core tracer indicators to measure progress toward UHC using existing review and reporting forums.	MOH Director PPME/GHS Director PPME	Jan-Mar 2017
C. Review and update existing SWIs with the view to prune them and focus them better on UHC objectives. Review routine data collection and reporting systems to ensure they include core indicators.	MOH IME working group*	Jun 2017
D. Provide tools and equipment and upgrade skills of personnel to improve capacity for maintaining a robust M&E system as part of process to close gaps in monitoring UHC.	MOH, health partners	Mar-Dec 2017
E. Identify/test additional tracer indicators to monitor NCDs, health of the aged, financial risk protection, and equity in service availability, and recommend for use.	GHS, National Health Insurance Authority	2017

*The Information Management and Evaluation (IME) health sector working group is chaired by the MOH and made up of representatives of MOH agencies and development partners in health. Its mandate is to review sector-wide indicators and recommend changes to its member institutions.

3.2. Recommendations for Longer-Term Action

The following outlines recommendations for the MOH and other stakeholders to track progress toward UHC over the longer term:

1. The MOH Directorate of PPME should work with a core group of agencies and individuals to build on the UHC strategy framework outlined by an informal think tank of experts (see Annex D for strategy).
2. The IME health sector working group should advocate use of existing indicators to measure progress toward achieving UHC. Few if any new ones are needed at this time.
3. The problem of overlaps, duplications, and misalignments within and between major data sets should be resolved through better coordination and communication between different parts of the health delivery system. The Director of the PPME Directorate and the IME health sector working group must take the lead in this exercise.

[4] Though the terms of reference gave a six-month time frame, the reality of missed deadlines and demands on time of responsible persons dictates a longer time frame.

4. To avoid the tendency to continually expand the range of indicators, a cap should be set on the number of tracer indicators for a defined period of time. Findings of this study suggest that a maximum of 20 such indicators should be used for a two-year period. Responsibility for finalizing and monitoring the use of the tracer indicators can be assigned to the IME working group. It should be completed in time for use in the next Health Sector Medium-term Development Plan 2018–2021.
5. The MOH and GHS should add value to the existing M&E Framework and procedures by insisting that all agencies use it. This requires accurate and timely communication on data needs and encouraging (through rewards and disincentives) the habit of using data for decision making at the points of collection as well as at managerial and policy levels.
6. The MOH Chief Director assisted by the directors of the MOH PPME Directorate and GHS should provide firm leadership to health sector stakeholders in addressing persistent gaps that retard progress of monitoring and diminish its quality.

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ANNEX A: UHC TWG MEMBERS

Name	Organization/Designation
Mr. Adams, Isaac	Ministry of Health
Mr. Adusei, Kofi	MOH-RHNP
Mr. Bigool, Mark	Ministry of Health
Mrs. Botchway, Mavis A.	MOH-CHC
Dr. Enyimayew, Nana	Consultant
Dr. Morrison, Isaac C.N	
Mr. Mahama, Osman	BEY-MOH
Dr. Martey, Maureen	Ministry of Health
Mr. Nyagbiornu, Nicholas	MOH-M&E
Mr. Nyakutsey, Benjamin	MOH-PAU
Dr. Odame, E.A	MOH
Mr. Otoo, Nathaniel	National Health Insurance Authority
Mr. Mensah, Alex Ofori	Christian Health Association of Ghana
Mrs. Tandor, Rita	EAC-MOH
Mr. Tsey, Lawrence K.	MOH-CIMU
Mr. Yorke, Emelyi Y.	MOH-PAU
Mr. Zuleiha, Amino	MOH-PAU

ANNEX B: PERSONS INTERVIEWED

Name	Organization/Designation
Ms. Amissah Arthur, Evelyn	African Development Bank (AFDB)
Dr. Boateng	Health Facilities Regulatory Agency
Mr. Amah d'Almeida, Selassi	World Health Organization (WHO)
Mrs. Dekou, Juliet Emefa	European Union
Mr. Issah Shamwill	U.K. Department of International Development (DFID)
Mrs. Itsuko, Shirontani	Japan International Cooperation Agency (JICA)
Mr. Kaluwa, Owen	WHO Representative to Ghana
Mrs. Kwateng-Addo, Akua	United States Agency for International Development (USAID)
Mr. Mensah Ofori, Alex	Christian Health Association of Ghana
Mr. Mogtari, Hudu	Food and Drugs Authority
Mr. Nyante, Felix	Nursing and Midwifery Council
Mr. Nyoagbe, Joseph	Registrar Pharmacy Council
Mr. Ngongalah Victor	United Nations Children Fund (UNICEF)
Mrs. Moshi, Magdalena	World Food Program (WFP)
Mr. Lee, Honn Sang	Korea International Cooperation Agency (KOICA)
Mr. Yeboah, Peter	Christian Health Association of Ghana

ANNEX C: KEY INFORMANT INTERVIEW QUESTIONS

1. Can you explain key objectives of your agency and how they contribute to the national goal to improve the health of all Ghanaians?
2. Does your agency have a formal statement, or policy, or programme or opinion on UHC?

   If not, what is your view on whether and how your agency should/can contribute to the attainment of UHC in Ghana?

3a. How does/would your agency measure progress toward the attainment of UHC?

3b. Specify/discuss indicators or measurements that are most relevant for your agency's goals and objectives especially in the context of the next Health Sector Medium-term Development Plan.

4a. What gaps have you identified in measurement of progress to UHC?

4b. In which ways can your agency work with MOH and its agencies to narrow these gaps?

ANNEX D. OUTLINE OF A UHC STRATEGY FOR GHANA

The consultant convened the informal think tank on UHC set up in September 2016 to help think through Ghana's strategy for UHC, how it would relate to the country's policy and strategy on primary health care and the WHO and World Bank definition of UHC, and whether what exists is sufficient to guide the country toward its goal of UHC. The expert group recommended that Ghana place equal emphasis on providing access to an essential health package and to financial risk protection, and not mainly on the latter as tends to be the case during key national discussions. Ghana's challenge is to design strategies that will accelerate progress toward full coverage of both dimensions.

With this in mind, Ghana's UHC strategy will:

A. Have a development focus. A UHC strategy should be the means to achieve the Sustainable Development Goal 3.

B. Use planning time frames that are aligned with national and international goals. These are the long-term national plan (40 years), medium-term plans (every four years), and annual sector plans.

C. Address the health needs of every Ghanaian but have the mother and child as the core target of an essential health service package.

D. Offer an essential health service package of preventive and curative services at each level of service delivery. The Ministry of Health (MOH), Ghana Health Service (GHS), and National Health Insurance Authority (NHIA) are working to harmonize existing packages for Ghana and ensure that the unified package adequately covers services needed to manage or prevent diseases that account for over 90 percent of the burden of diseases.[5] Extra attention is required for non-communicable diseases and geriatric care.

E. Deliver services through the existing three-tiered district health system with each district divided into subdistricts (Level B) and Community Health Planning and Service (CHPS) zones (Level A). The district hospital and District Health Management Team (Level C) will serve as referral center and oversight management body, respectively. The mode of service delivery will vary somewhat between rural and urban settlements.

   The CHPS compound is the primary contact that most households have with the formal health services. Compounds will be expanded to cover the entire country. Currently, less than 60 percent of CHPS compounds and health centers have the capacity to provide the National Health Insurance Scheme (NHIS) package of services. A networked model of service delivery is expected to improve capacity to deliver quality of services at the primary level[6] and will be adapted for use after field-testing. Such a model will also facilitate the development of a referral system with a gate-keeper function that will increase efficient use of existing services and resources and ensure timely care to all.

F. Focus on health service organization and delivery that is decentralized to the Local Government system.

   Until now, health service planning and organization has been significantly decentralized along the MOH axis and has largely ignored the authority of the Local Government system.

[5] Ministry of Health. July 2016. Ghana Burden of Disease Study for 2013.

[6] From a draft document on the design of a project on UHC through primary health care, version February 2017, which is being prepared jointly by MOH, GHS, NHIA, and USAID.

Renewed efforts to develop a more effective decentralized Local Government system has resulted in the preparation of a Health Bill 2016 that give legal backing to the government decision on migration of the district- and subdistrict-level functions and staff of the GHS to the Local Government system and subsequently to exist as a devolved Department of Health (DOH) of the Metropolitan, Municipal and District Assemblies. The functions of the DOH include to advise on collection of health statistical data and to facilitate the collection and analysis of data on health. This raises the possibility that existing information management procedures at the district level will be disrupted at least during a transition period.

One way of avoiding this disruption is to use the tested and tried structure of the Centre for Health Information Management (CHIM), which has the historical mandate of collecting health service data. CHIM should be given more policy backing to use its existing structures and systems – like the District Health Information Management System (DHIMS2) – to enhance the data collection from the devolved districts.[7]

G. Prioritize financing arrangement for health services: The key national goal in financing health services is to achieve 100 percent NHIS population coverage funded by taxes and premium contributions, thereby removing financial barriers for the poor and achieving better equity in access to and utilization of service. Other sources of health financing to focus attention during the next decade are the central government funds, and employer financing of employee insurance premiums.

   Efficiency gains through better planning and coordination, redistribution of human resources in a way that minimizes waste, and losses used to mobilize additional resources for service delivery.

H. Measure progress toward stated objectives using the DHIMS2, the annual health sector review process, the Ghana Demographic and Health Survey (GDHS), the Multiple Indicator Cluster Survey (MICS), the Ghana Living Standards Survey (GLSS), and other surveys.

[7] Director of Monitoring and Evaluation, GHS. October 2016. Personal conversation.

ANNEX E: HEALTH INDICATORS IN GHANA 2016

This annex contains a summary of Ghana's comprehensive list of 287 indicators (Annex E1) and the Ministry of Health (MOH) standard list of sector-wide indicators (SWIs) (Annex E2), both of which are published in the MOH M&E Framework of 2014. Annex E2 has an accompanying table showing differences with the SWIs presented in the Holistic Assessment Tool 2014, which is a more recent publication. Annex E3 presents a smaller set of sector wide indicators used by the National Development Planning Commission to gain an overview of health sector performance and can be likened to tracer indicators. These are selected in consultation with the MOH. Annex E4 is a summary of survey indicators used to monitor demographic and health status of the Ghanaian population.

Annex E.1: Summary of Ghana's Comprehensive List of Health Sector Indicators

Programs and Services	Type	No. of Indicators
Group A: Clinical Services	Outpatient Department	12
Group A: Clinical Services	Inpatient Department	60
Group A: Clinical Services	Rational Use of Drugs	5
Group A: Clinical Services	Blood Transfusion Service	18
Group A: Clinical Services	Institutional Rates and Survey Mortality Rates	8
Group B: Reproductive Health	Antenatal Care	14
Group B: Reproductive Health	Delivery	9
Group B: Reproductive Health	Postnatal Care	5
Group B: Reproductive Health	Adolescent Care	14
Group C: Family Planning	Family Planning	5
Group D: Tuberculosis	Tuberculosis	9
Group E: Child Health	Neonate	11
Group E: Child Health	Under-five	5
Group E: Child Health	Expanded Programme on Immunisation	26
Group E: Child Health	Child Welfare Clinic	7
Group E: Child Health	School Health	8
Group F: Malaria	Malaria	22
Group G: HIV/AIDS	HIV/AIDS	32
Group H: Human resources	Human Resources	10
Group I: Occupational Health	Occupational Health	7
All Groups		287

Annex E.2: Health Sector-Wide Indicators

Ref no.	Indicator
Objective 1: Bridge the equity gaps in geographical access to health services	
1.1	Number of functional ambulance centres
1.2	Number of functional CHPS zones
1.3	Outpatient attendance per capita (OPD)
1.4	Equity: Under-five mortality ratio- Ratio of first wealth quintile to fifth wealth quintile
1.5	Equity: Geography - Supervised deliveries- Ratio of best performing region to worst performing region
1.6	Doctor: population ratio
1.7	Equity: Geography - Ratio of best performing region to worst performing region (nurse: population ratio)
1.8	Equity: NHIS - Gender (Female/Male cardholder ratio)
Objective 2: Ensure sustainable financing for health care delivery and financial protection for the poor	
2.1	% total Medium-term Expenditure Framework (MTEF) allocation on health
2.2	Per capita expenditure on health (USD)
2.3	Budget execution rate (Item 3 or Service as proxy)
2.4	% of population with active NHIS membership card
2.5	% of total budget financed through internally generated funds (IGF)
Objective 3: Improve efficiency in governance and management of the health system	
3.1	% restaurants and food vendors in good standing Not in HAT 2015
3.2	Doctor:population ratio
3.3	Nurse:population ratio (including CHNs)
3.4	Midwife:population ratio
3.5	% nursing and midwifery licensure pass rate
3.6	% health facilities duly registered
3.7	% National Health Insurance Fund (NHIF) budget released to NHIS
3.8	% NHIS claims settled with 12 weeks
3.9	% health budget (goods and services) allocated to research activities
*	% GOG budget spent on assets
*	% health budget (goods and services) allocated to research activities
Objective 4: Improve quality of health services delivery including mental health services	
4.1	Institutional all case mortality
4.2	% of region and district public hospitals offering traditional med practice
4.3 *	% of public health hospitals with a mental health unit % of public hospitals offering mental health services
4.4	Institutional malaria under-5 case fatality rate
4.5	Surgical site infection rate
4.6	% of public hospitals with trained emergency team
Objective 5: Enhance national capacity for attainment of the health-related Millennium Development Goals (MDGs) and sustain the gains	
5.1	Unmet need for contraception
5.2	Family planning coverage (CYP) – all sources including private sector
5.3	Infant Mortality Rate (IMR) per 1,000 live births
5.4	Institutional Neonatal Mortality Rate
5.5	Neonatal Mortality Rate
5.6	Under 5 Mortality Rate (U5MR) per 1,000 live births
5.7	Maternal Mortality Ratio (MMR) per 100,000 live births
5.8	Institutional Maternal Mortality Ratio
5.9	HIV prevalence rate

Ref no.	Indicator
5.10	% of infected pregnant women who received ARVs for prevention of mother-to-child transmission (PMTCT)
5.11	% of babies born to HIV mothers being HIV negative after 18 months
*	% eligible adults and children currently receiving antiretroviral therapy (ART) among all adults and children living with HIV
*	% of pregnant women tested for HIV and received results for PMTCT
5.12	% of children under 5 who are stunted
5.13	% of children fully immunized by age one – Penta-3 coverage
5.14	% of pregnant women attending at least 4 antenatal visits
5.15	% infants who had exclusive breast feeding for six months
5.16	% of deliveries attended by a trained health worker
5.17	Still birth rate
5.18	Postnatal care coverage for newborn baby
5.19	% of children under 5 years sleeping under insecticide-treated nets (ITNs)
5.20	TB treatment success rate
Objective 6: Intensify prevention and control of non-communicable and other communicable diseases	
6.1	Non-AFP polio rate
6.2	Population prevalence of hypertension
6.3	Number of deaths attributable to selected cancers
*	Guinea worm surveillance: % of suspected guinea work cases reported that are investigated
*	% of OPD attendance due to malaria
*	6.2 and 6.3 of MOH SWI 2014 are not listed in HAT SWI

Annex E.2: Supplement: Comparison of Three Sets of Sector-wide Indicators

	M&E Framework (2014)[8]	HSMTDP (2014)	HAT (2015)
No. of indicators	53	52	54
No. of health sector objectives	6	6	6
No. of changes from reference list	-	7	27
Excluded indicators (Ref)	-	1 (5.10)	8 (1.8; 2.5; 3.1; 3.5; 5.10; 5.11; 6.2; 6.3)
Additional indicators[9] (Ref)	-	0	10[10]
Reworded indicators[11] (Ref)	-	6 (1.7; 2.2; 3.4; 3.6; 4.3; 5.2)	9

[8] The SWI in the M&E Framework (2014) developed to guide monitoring of the HSMTDP 2014-2017. This report uses it as the reference list against which to compare other lists in use.
[9] Refers to indicators not listed in M&E Framework (2014).
[10] Reference numbering in HAT (2015) is different from M&E Framework (2014) for several indicators because of exclusions and additions. The reference numbers for additions [A] and reworded indicators [B] in the HAT (2015) SWI are listed in this footnote in square brackets [A: 1.6; 2.5; 2.6; 2.7; 2.8; 3.6; 3.7; 3.8; 6.3] (B: 1.8; 2.2; 3.4; 3.6; 3.7; 4.3; 4.6; 5.2; 5.14)
[11] Refers to indicators that are in M&E Framework (2014) but have been reworded in part or in full in the other versions of SWI.

Annex E.3: Health Sector Indicators from the National Development Planning Commission[12]

Policy Objectives and Their Indicators

1. Reduce under-nutrition and malnutrition-related disorders and deaths among infants and young children.
    - Under 5 malnutrition rate.
2. Ensure optimal nutrition among all segments of population.
    - Obesity in adult population (women age 15-49 years).
3. Bridge equity gap in access to health care.
    - Number of functional Community-based Health Planning Services (CHPS) zones.
    - Per capita Out Patient Department (OPD) attendance.
4. Ensure sustainable financing for health care delivery and financial protection of the poor.
    - Percentage of the population with valid National Health Insurance Scheme (NHIS) card.
5. Improve efficiency in governance and management of health system.
    - Per capita expenditure on health.
6. Improve quality of health service delivery, including mental health services.
    - Doctor-to-population ratio.
    - Nurse-to-population ratio.
    - Midwife to woman in fertile age (WIFA) population ratio.
    - Number of community psychiatric nurses trained and deployed.
7. Enhance national capacity for attainment of health-related Millennium Development Goals (MDGs) and sustain the gains.
    - Infant mortality rate.
    - Under-5 mortality rate.
    - Percentage of children immunized (Penta 3).
    - Institutional maternal mortality ratio.
    - Percent of supervised deliveries.
    - Institutional under-5 malaria case fatality rate.
    - Tuberculosis (TB) treatment success rate.
8. Ensure the reduction of new HIV and AIDS/STI/TB infections especially among the vulnerable.
    - HIV prevalence among pregnant women 15-24 years.
    - HIV prevalence rate.

[12] Source: National Development Planning Commission. December 2015. Ghana Shared Growth and Development Agenda (GSGDA) II, 2014-2017, Results Framework, Volume III Results Architecture and Key Performance Indicators (KPIs).

9. Improve HIV and AIDS/STI case management.
    - HIV clients receiving antiretroviral (ARV) therapy.
    - Proportion of infected pregnant women who received ARVs for prevention of mother-to-child transmission (PMTCT).

Annex E.4: Sections and Number of Indicators in Ghana Demographic and Health Survey 2014

Section	Heading	No. of Indicators
1	Introduction	0
2	Housing Characteristics (includes access to water and sanitation)	8
3	Respondent Characteristics	6
4	Marriage and Sexual Activity	7
5	Fertility	9
6	Fertility Preferences	5
7	Family Planning	16
8	Infant and Child Mortality	6
9	Maternal Mortality	6
10	Child Health and Early Development	9
11	Nutrition of Women and Children	11
12	Malaria	9
13	HIV/AIDS – Knowledge Attitudes and Behaviours	19
14	HIV/AIDS – Prevention	15
15	Adult Health and Life-style	9
16	Women Empowerment and Demographics and Health Outcomes	16
All sections		139

Annex E.5: Sources of Health Sector Data

Source	Most Recent
Routine administrative data	2015
Ghana Demographic Health Survey	2014
National Population Census. Conducted every 10 years since 1960.	2014
HIV Sentinel Surveys. 24 reports since 1986	2015
Multiple Indicator Cluster Survey (MICS). 4 rounds conducted. Data evaluate health service performance and utilization coverage.	2011
Ghana Living Standards Survey (GLSS). 6 rounds conducted; round 7, for 2016/17, in progress. GLSS collects data for monitoring the impact of national policies and programs on the welfare of the population.[13]	2012/13
National Health Accounts (NHA). Conducted on data from 2000 and 2010. Provides evidence to monitor trends in health sector spending; helps develop strategies for effective health financing and raise additional funds for health; enables comparison with the country's past health expenditures and with expenditures of other countries.[14]	2010
Holistic Assessment of Health Sector Programme of Work.[15] Used to assess sector performance and identify factors that influence performance.	2016
Demographic Surveillance System (DSS), Kintampo and Navrongo districts. Records demographic events (pregnancies, births, deaths, migration within the districts' population at six month intervals).	

[13] Dominic Mensah. 6 Oct 2016. Seventh Ghana Living Standards Survey Launched. Graphic on line www.graphic.com.gh.
[14] WHO. https://knoema.com>WHONHA2014
[15] MOH. June 2016. Holistic Assessment of the Health Sector Programme of Work 2015.

ANNEX F: WHO/WORLD BANK-RECOMMENDED TRACER COVERAGE INDICATORS COMPARED WITH INDICATORS IN USE

Tracer Indicator	Corresponding Ghana Indicator
1. Family planning	Family planning coverage: Couple year protection
2. Antenatal care	% women receiving antenatal care from a skilled health worker at least 4 times during pregnancy
3. Skilled birth attendant	% of deliveries attended by trained health worker
4. Child vaccination: DPT – three doses	% children received Pentavalent 3 by age 1
5. HIV treatment:	% HIV+ pregnant women on antiretroviral (ARV) for prevention of mother-to-child transmission (PMTCT)
6. Tuberculosis control	% patients who are proven cured using smear microscopy at the end of treatment
7. Improve water source	% households with access to safe drinking water
8. Improved sanitation	% households with improved sanitation
Candidates for tracer indicators	
9. Non-communicable disease (NCD): Hypertension (HT) treatment coverage. % of hypertensive patients currently taking medication and have BP below 140/90mmHg.	% 15-49 with HT who are currently taking anti-HT medicine[16]
10. NCD: Type 2 diabetes treatment coverage % diabetics currently taking medication and have fasting blood sugar at or below 7.0mmol/L	Reported at hospitals. Not estimated in national surveys. Not in list of sector-wide indicators.
*Malaria control and treatment: insecticide-treated net (ITN) use among children/pregnant women	% of outpatient attendance diagnosed as malaria
* Epidemic-prone diseases	*Cholera cases
Other promising health service indicators	
11. Cataract surgical coverage (indicates access to care by the elderly)	Not routinely reported or estimated. Not in national list of indicators
12. Preventive chemotherapy for neglected tropical diseases (diseases of the most deprived of population)	Not routinely reported but data on lymphatic filariasis collected during mass community drug distribution and available by region.[17]
13. Mental health: Depression treatment	Not routinely reported or estimated
14. Palliative care	Not routinely reported or estimated
15. % 15-year-olds or more who have not smoked tobacco in the past 30 days	% 15-49 years who smoked or used tobacco products within past 24 hours

[16] Estimated for the first time in Ghana Demographic and Health Survey (GDHS) 2014. Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014. Rockville, Maryland, USA: GSS, GHS, and ICF International.

[17] Director M&E, GHS, October 2016. Personal communication

Tracer Indicator	Corresponding Ghana Indicator
Financial protection indicators	
16. Catastrophic health expenditure % of households whose health expenditures are equal to or greater than the agreed threshold	% 15-59 years reporting out-of-pocket payment for medicine and health services[18]
17. Impoverishing expenditure % of households pushed below poverty line by out-of-pocket payments [through household surveys]	No routinely collected data

[18] GDHS 2014. More than one-third of NHIS card holders reported paying out of pocket for medicines and services. One-third of card holders needed services not covered by National Health Insurance Scheme.

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